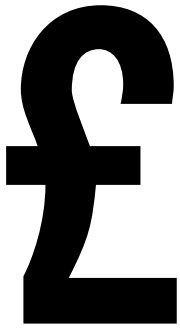
Association of Personal Injury Lawyers

MANAGING THE COST OF MEDICAL NEGLIGENCE CLAIMS



A STRATEGY FOR IMPROVEMENT

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WHAT IS THIS DOCUMENT?

At a time when the government is about to consult on fixing legal costs in medical negligence claims as a way of promoting 'better litigation' and reducing the costs of these claims to the public purse, it is vital that all avenues are explored. In this paper, we look at some of the options available to the Government and the NHSLA with the aim of ensuring a rational and rounded debate on the issue.

Every day people walk into hospitals or doctors' surgeries and put their trust in the clinicians who care for them. Almost every time, this is a positive experience. Very occasionally, things go wrong. In three per cent of those cases, as a result of negligent decisions or actions on the part of clinicians, the error will lead to a claim being made by the injured person. See Fig.1 below, for details of the percentage of injuries compared to the number of claims made.

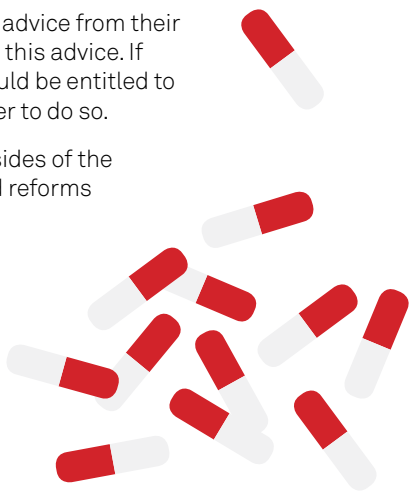
There are birth injuries, or misdiagnosed or mis-treated illnesses, for example. No-one expects to be injured as a result of medical negligence, but if they are, they deserve to be properly compensated.

Fig. 1 {Number of people injured year on year and the percentage of those who make a claim}

Year	CRU - Clinical Negligence claims made	NHS National Reporting & Learning Service (NRLS) - adverse incidents causing harm	Percentage of those claiming compared to the number of injuries
2013/14	18,499	470,197	3.93%
2012/13	16,006	458,348	3.49%
2011/12	13,517	419,898	3.22%

There are some key principles which underlie this document:

- **Damages should not be reduced**. It is a basic tenet of the Common Law that injured people are entitled to be put back, so far as damages can achieve this, in the position they were prior to the negligent act.
- **Access to justice should be maintained**. The proposals should not prevent people bringing justified claims.
- **The quality of casework should not be undermined**. Proposals which deter the inexperienced solicitor and encourage the specialist will save money for the NHS and NHSLA in the long run. The lowest common denominator must not become the standard. To do otherwise will inevitably lead to additional defendant costs being incurred as a result of having to deal with incompetent or inexperienced claimant legal representatives or litigants in person.
- **The changes should not apply retrospectively**. Clients who have already received advice from their solicitor about the likely costs of pursuing their claim should be entitled to trust in this advice. If they have already been given advice about how they will fund their claim, they should be entitled to rely upon that advice and upon the binding contracts they have put in place in order to do so.
- **Reforms must be even-handed**. Positive improvements should be made on both sides of the litigation process: claimant and defendant. This is not a one-sided costs issue and reforms must be fair.



SAVING TIME & MONEY FOR THE NHSLA

Claims cost money, and in an environment of cost cutting there is a pressure to bring down the cost of settling claims. There is no bottomless purse and this strategy document examines how to save time and money, while remembering those who suffer as a result of a medical mistake. This paper also examines how to reduce the incidence of medical negligence in the future. The easiest and best way way to cut the compensation bill is to cut the level of medical negligence.

1. The cost of claims – the 'LASPO effect'

By allowing for the effects of the changes brought in by the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012, the costs and expenses paid out by the NHSLA will automatically be reduced by around a third. This means that the NHSLA is already going to save one third of the sums it pays out, by doing nothing at all.

In claims worth less than £25,000 those savings add up to an impressive 39 per cent, equivalent to £71,033,478 per year.

Because medical negligence cases typically take several years to resolve, the data currently available to the NHSLA does not reflect these substantial cost savings that have recently been introduced by LASPO.

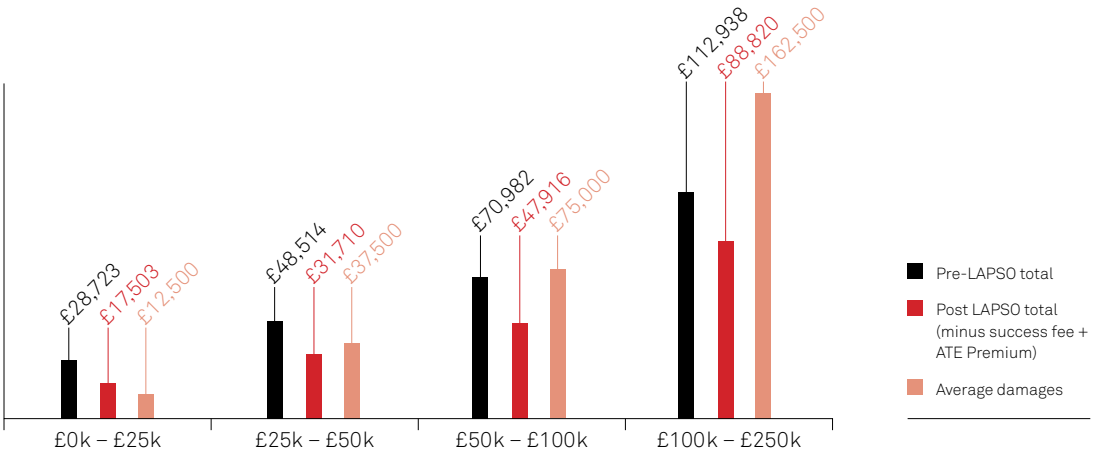
According to the data APIL has collected from claimant practitioners, nearly half of the 'legal costs' paid by the NHSLA to claimant lawyers can be accounted for by success fees, ATE premia, court fees, and experts' fees.

Since April 2013 both a large proportion of the ATE premium and all of the success fee have been paid by the claimant out of damages rather than by the NHSLA when it loses a claim. For this reason, the sums which the NHSLA says it pays to claimants give a misleading picture.[1] In fig.2and fig.3 below we have looked at some of our members' claims and adjusted the figures to show a pre- and post LASPO picture, removing the historical bias. The final column clearly indicates the automatic savings from which the NHSLA is already going to benefit, in relation to all claims which started after April 2013.

Fig.2 {PRE and Post LASPO: Successful cases settled 12 months to 31st March 2013, showing percentage change in overall spend}

Claim value	Solicitor costs (£)	Success fee (£)	Expenses (inc medics' fees and court fees) (£)	ATE Premium (£)	Counsels Fees (£)	TOTAL	Minus Success Fee + ATE Premium	% Savings
£0 - £25k	£11,547	£7,530	£4,728	£3,689	£1,228	£28,723	£17,503	39%
£25k - £50k	£18,968	£11,363	£10,274	£5,441	£2,469	£48,514	£31,710	35%
£50k - £100k	£28,711	£14,562	£14,719	£8,504	£4,485	£70,982	£47,916	32%
£100k - £250k	£66,210	£15,679	£17,572	£8,440	£5,038	£112,938	£88,820	21%
£250k +	£206,510	£21,534	£30,039	£20,081	£17,497	£295,662	£254,047	14%
						Total Average Savings		28%

Fig.3 {PRE and Post LASPO: Successful cases settled 12 months to 31st March 2013, showing change in overall spend}



2. Screening claims

Whereas establishing liability is often straightforward in a car crash, that isn't the case for medical negligence claims. For example, the electronic portal statistics show that for RTA claims, an admission of liability is received in 67.66% of claims at stage one of the process with a further 27% of the total number of claims each month being settled by the end of stage two – that's 94.66% of RTA claims settled pre-issue.[ii]

In medical negligence claims, firms report turning away up to 85% of the potential claims which come through their door before they even start. Of the 15% which proceed, early admissions may only be secured on a small percentage of those claims, with only 70.4% eventually settling pre-issue.

Law firms dismiss around 85% of potential medical negligence claims by applying a screening process in the early stages of their dealings with potential clients.

Screening is the practice of risk-assessing cases using a panel of experienced legal and medical practitioners who will weed out those cases which have poor prospects of success. The costs of screening are carried by the firm as a necessary overhead. For example, Irwin Mitchell (a firm with an excellent reputation for running medical negligence claims) has a screening process as follows:

- Initial enquiries are usually dealt with by phone. The caller is asked questions about the claim and obvious issues such as the date of the alleged medical negligence or the nature of the claimant's relationship to the injured person will screen out claims which are beyond the limitation period, have already been settled within the deceased patient's lifetime or dependents who have no standing, for example.
- Claims which get beyond this stage will be subject to the usual checks, a client history, witness evidence and medical records will be sought. At that stage, more claims will be screened out as having poor prospects of success.
- Further claims will be screened out once initial medical reports have been obtained from an expert.
- All of these steps are taken before the NHS LA has any knowledge that a claim is being considered by the claimant. The NHSLA remains unaware of the work being done and, crucially, the costs of this work are borne by the law firm, the client and the client's ATE insurer.

Effects of screening on costs

There is a genuine concern that if legal fees are fixed too low, screening will become an unaffordable luxury. This would have an adverse impact on the number of claims being put to the NHSLA. Rather than weeding out the claims least likely to succeed, it will prove cheaper for claimant lawyers to lodge all claims, forcing the defendant NHS Trust or NHSLA to do the screening work instead – at extra cost to the public purse. This would be cost shifting, not cost reduction.

'LOW VALUE' CLAIMS

Before we proceed, it is necessary to identify what constitutes 'low value' and understand the procedures involved in a medical negligence claim.

Our composite flow chart (fig.4) sets out the actions and decisions involved in a 'standard' low value medical negligence claim process.

In our view, medical negligence claims valued at up to £25,000 are 'low value' in line with the other low value pre-action protocols. The reasons for this are:

- A fixed fee scheme already exists in other areas of personal injury: road traffic claims, employers' liability and public liability claims are subject to the low value pre-action protocols which fix both procedures and costs for claims valued at up to £25,000. "Low value" is not a relative concept that can shift according to how an injury is caused.
- Claims valued at £25,000 or less are subject to the court's fast track, which limits trials to one day only and allows for only one expert to be instructed;
- In 2013 APIL and AvMA worked with the NHSLA on a proposed a fixed fee scheme for claims valued between £1,000 and £25,000. At that time, the NHSLA accepted that claims worth £25,000 or less were 'low value';
- Claims valued at more than £25,000 inevitably involved more than one expert and any of these claims which eventually go to trial will need more than one day to resolve issues of liability and causation.

We accept that Fig.2 and 3 above show that fees in lower value cases are higher as a proportion of damages compared to higher value claims, but there are good reasons for this. It is crucial to bear in mind that it is the claimant who must prove the claim. There is always a minimum amount of work which has to be done at the start of any claim, regardless of value. This work is clearly set out in stage 1 of the flowchart (fig.4). In lower value claims, the minimum amount of necessary work is expensive. There are, though, in our view, savings which can be made with suitable reform of the current system, as are outlined below.

3. Fixing legal costs and expenses in low value claims

A fixed fee scheme in medical negligence for low value claims could be workable provided:

- The fees are set at a level which makes the work viable;
- The claims process itself is standardised or 'fixed';
- The quality of the work or legal practitioner remains at an experienced level: reducing the level of experienced practitioner conducting these claims will cost the NHSLA more in the longer term;
- Liability (breach of the duty of care and causation) has been admitted;
- Only one medical report is required.

A fixed fee scheme for medical negligence cases is not a new idea. As already discussed above, in 2013 APIL and AvMA worked with the NHSLA on a proposed fixed fee scheme for claims valued between £1,000 and £25,000.

REDUCING COSTS IN MID TO HIGH VALUE CLAIMS

Mid to high value claims follow a different path from low value cases and are not suited to fixed costs. To demonstrate this, we have looked at the process they go through and illustrated it in a series of flowcharts.

Fig.5 {Flowchart for claims worth more than £25,000} {See following page}

4. Properly experienced practitioners

The majority of claims valued at more than £25,000 require more than two medical reports (one on each side). In very complex birth injury claims, we have seen cases where eleven quantum experts have been necessary for each party. Claims valued at over £25,000 require an experienced legal practitioner to oversee. This is not an 'entry level' job that any solicitor can do: it requires specialism and expertise to get the right answer for the client and ensure that the claim is run in an efficient and correct fashion. Doing the work at too low a level means that issues are missed, unmeritorious claims are run, large claims are under-settled and unnecessary work is done, costing both the NHSLA and the claimant more.

5. Early admissions of liability

Where unreasonable medical care has injured a patient, compensation should be paid quickly and fairly, obviating the need for costly litigation.

But liability is rarely admitted in full or at all by the NHSLA at the start of the claim. Even when it does admit the breach, the NHSLA still routinely argues that the breach did not cause any loss (the causation argument).

There are many cases where there is clear fault, but the tendency, particularly with the mid-higher value claims, is to 'deny and defend' in the hope that they will go away (this is one of the reasons you can never have a fixed cost scheme for cases where liability is not admitted – you just get priced out of the case). Examination of our flow charts (fig.4 and fig.5) shows that a combined 29.6% of cases settle after the case has been issued.[iii] If they settled at stage 3, rather than at stage 4 of the flow-charts, it is obvious that substantial time and legal costs could be saved on both sides. Most of the work in stage 4 in fact is done by the claimant's lawyers to prepare the case for issuing court proceedings. The defence has all the information it needs to make a decision to settle during stage 3.

A review should be undertaken at the NHSLA of all cases where admissions were made or damages paid to the claimant with a view to learning how to speed up the decision making process and promote earlier settlement.

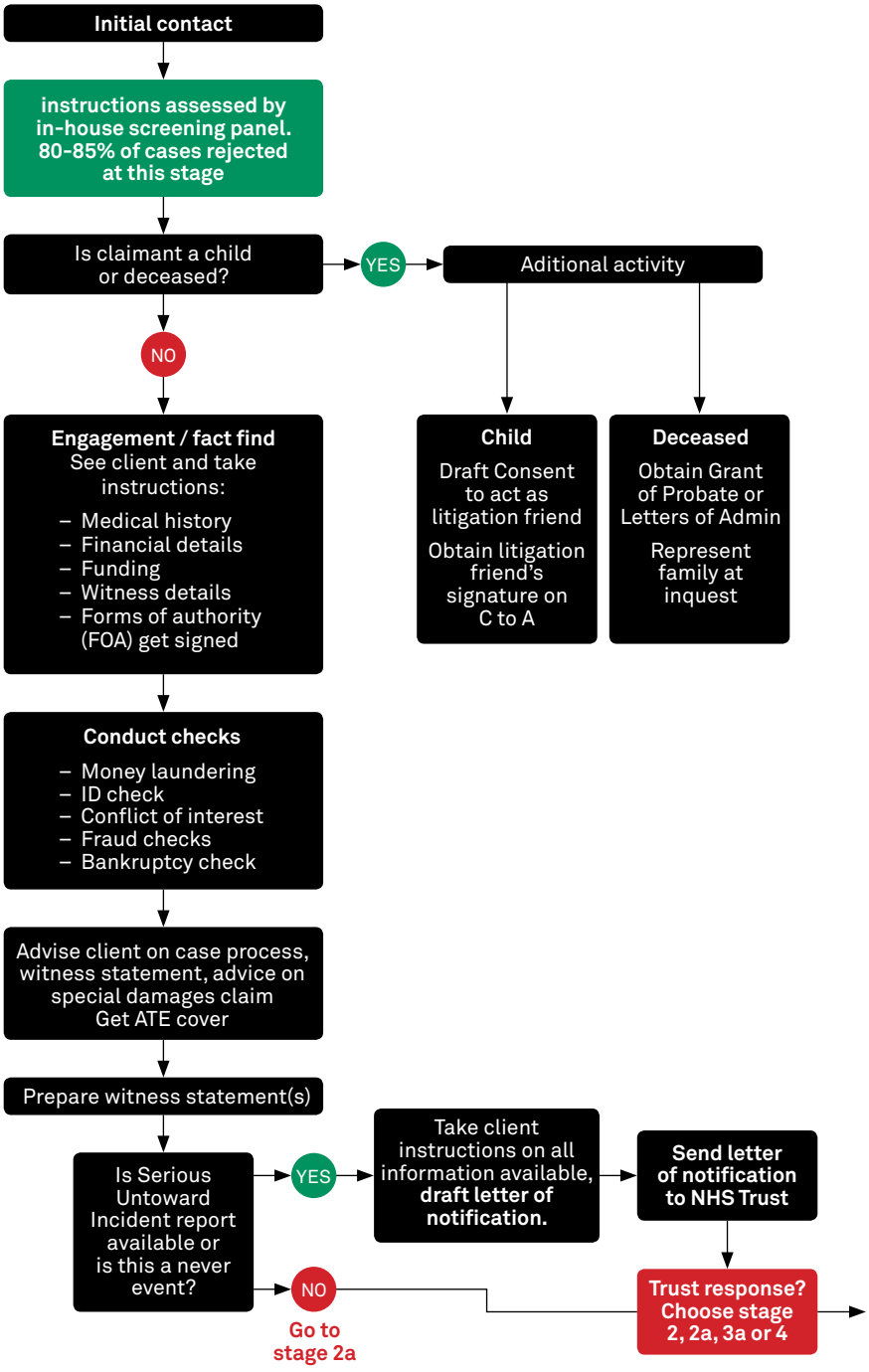
6. Consistency

One of the causes of inconsistency is that individual NHS Trusts have their own legal teams who deal with most claims in-house at the outset. Claims are then passed to the NHSLA at different stages, depending on the individual Trusts' policies. If the claim is issued in court, then it is passed by the NHSLA to external defendant lawyers. There are, we know, inconsistent decisions being made in all three of these stages. The NHS in-house teams and the NHSLA, perhaps bound by clinicians who do not want an admission of fault on their record, appear to find it difficult to adopt a consistent and reasonable stance. Anecdotally the NHSLA settles some cases immediately, while contesting other claims despite the evidence being the same.[iv]

A review should be undertaken at the NHSLA, in collaboration with the in-house NHS legal teams, with a view to learning how to standardise decision making on the liability issues of breach of duty and causation, to ensure that decisions are consistent across the system.

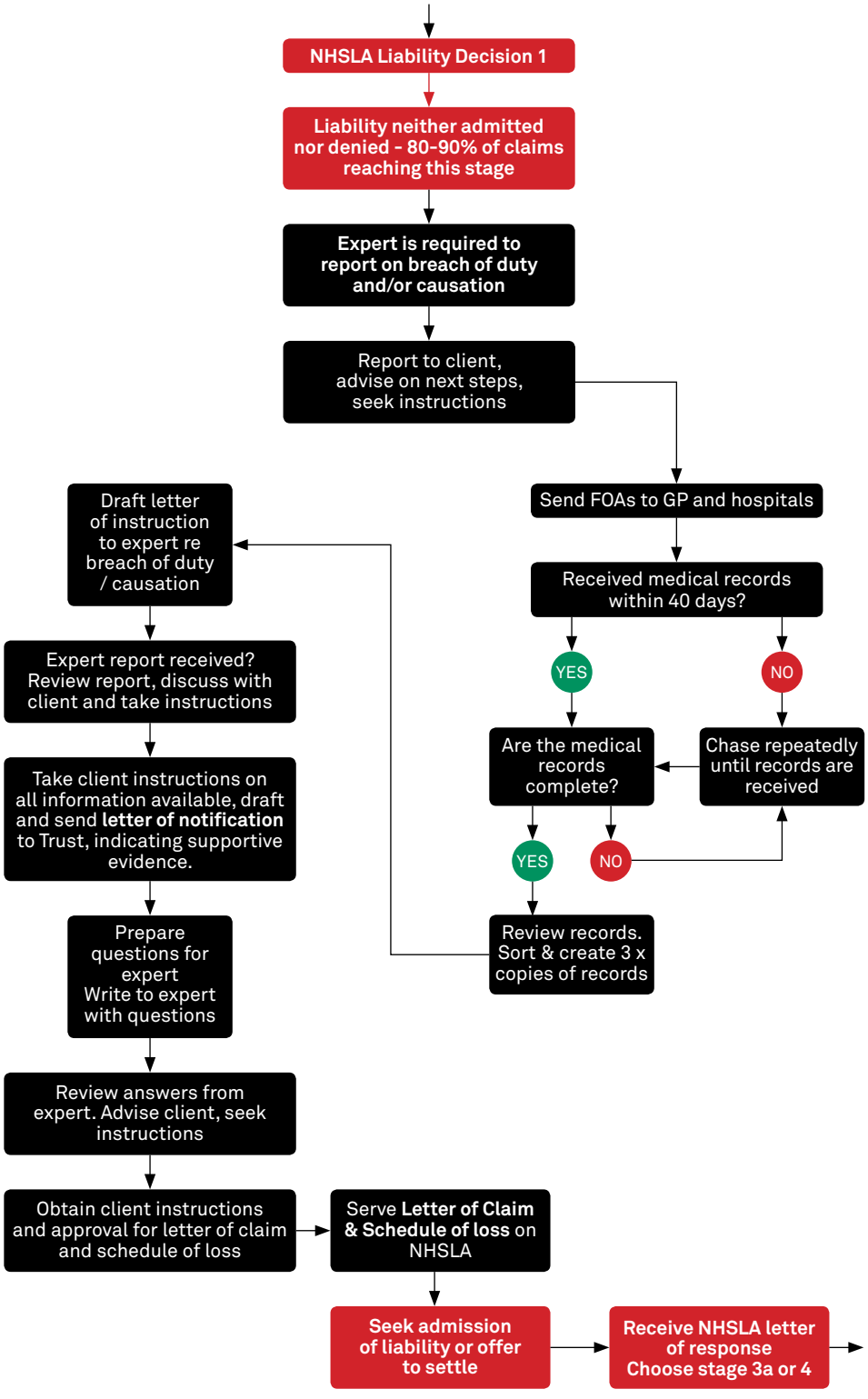
MEDICAL NEGLIGENCE CLAIMS UNDER £25,000

STAGE 1


Initial contact
instructions assessed by in-house screening panel. 80-85% of cases rejected at this stage
Is claimant a child or deceased?
YES
Aditional activity
NO
Child
Draft Consent to act as litigation friend
Obtain litigation friend's signature on C to A
Deceased
Obtain Grant of Probate or Letters of Admin
Represent family at inquest
Engagement / fact find
See client and take instructions:
– Medical history
– Financial details
– Funding
– Witness details
– Forms of authority (FOA) get signed
Conduct checks
– Money laundering
– ID check
– Conflict of interest
– Fraud checks
– Bankruptcy check
Advise client on case process, witness statement, advice on special damages claim
Get ATE cover
Prepare witness statement(s)
Is Serious Untoward Incident report available or is this a never event?
YES
Take client instructions on all information available, draft letter of notification.
Send letter of notification to NHS Trust
NO
Go to stage 2a
Trust response? Choose stage 2, 2a, 3a or 4

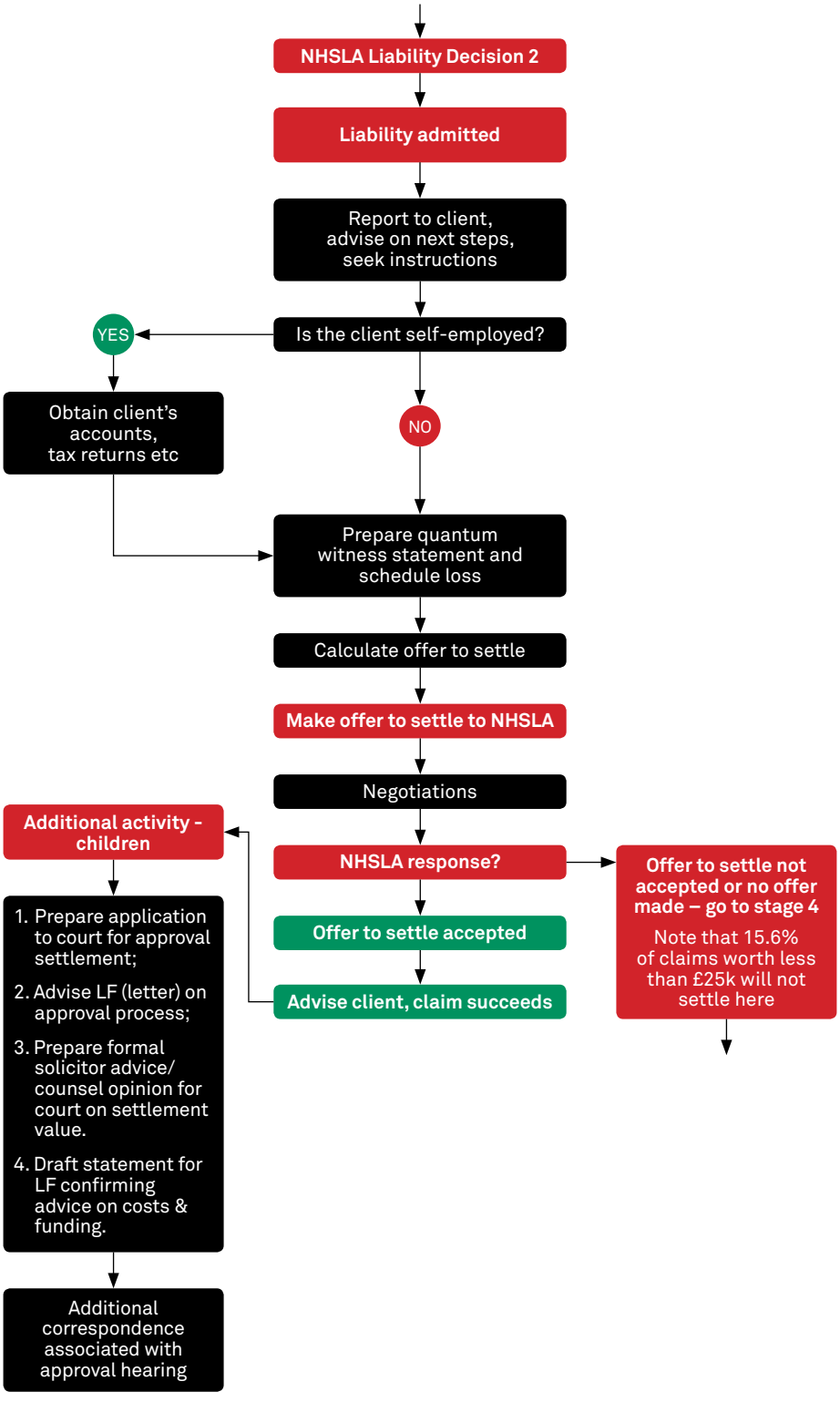
MEDICAL NEGLIGENCE CLAIMS UNDER £25,000

STAGE 2a


NHSLA Liability Decision 1
Liability neither admitted nor denied - 80-90% of claims reaching this stage
Expert is required to report on breach of duty and/or causation
Report to client, advise on next steps, seek instructions
Send FOAs to GP and hospitals
Received medical records within 40 days?
YES
NO
Are the medical records complete?
Chase repeatedly until records are received
YES
NO
Review records. Sort & create 3 x copies of records
Draft letter of instruction to expert re breach of duty / causation
Expert report received? Review report, discuss with client and take instructions
Take client instructions on all information available, draft and send letter of notification to Trust, indicating supportive evidence.
Prepare questions for expert Write to expert with questions
Review answers from expert. Advise client, seek instructions
Obtain client instructions and approval for letter of claim and schedule of loss
Serve Letter of Claim & Schedule of loss on NHSLA
Seek admission of liability or offer to settle
Receive NHSLA letter of response Choose stage 3a or 4

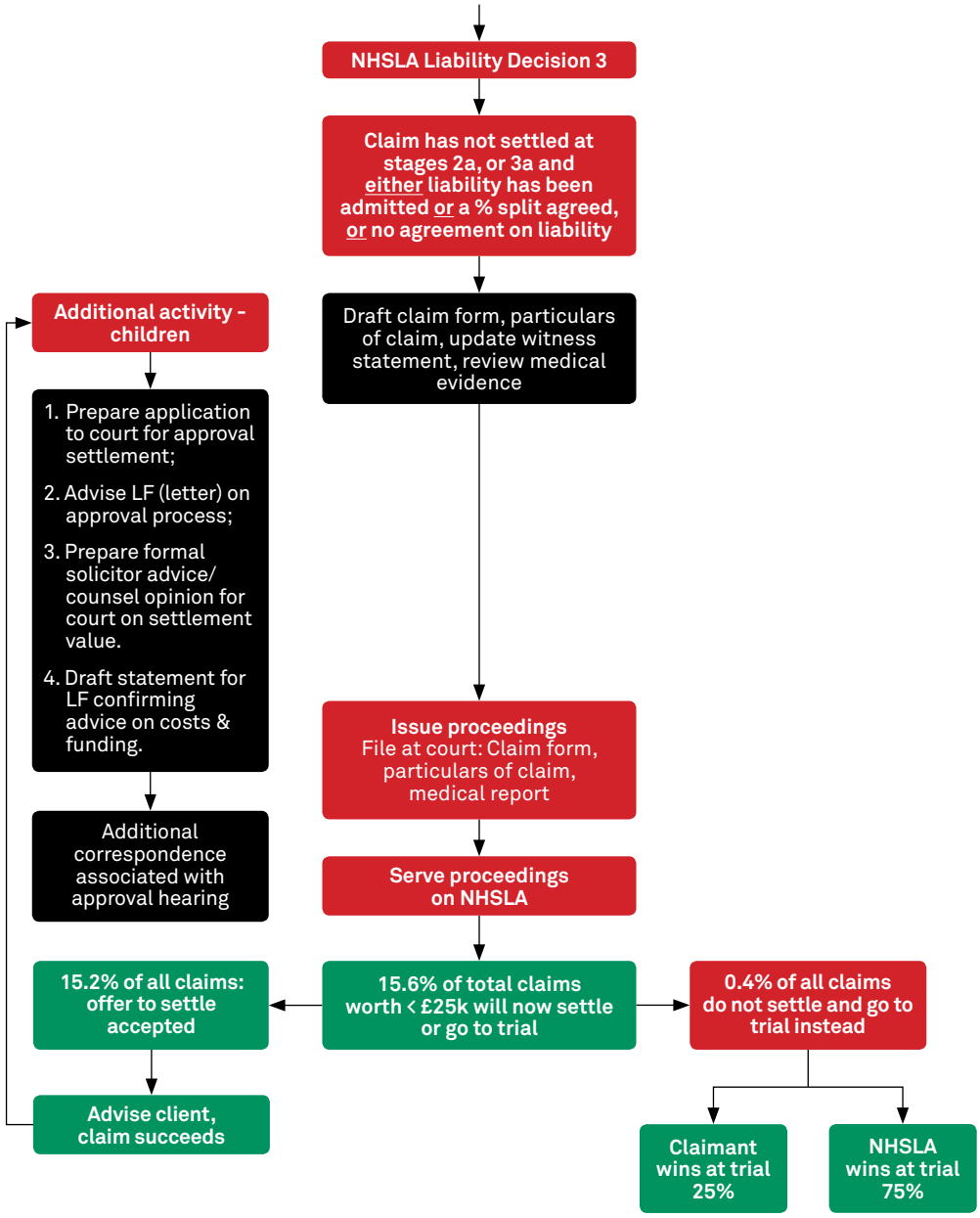
MEDICAL NEGLIGENCE CLAIMS UNDER £25,000

STAGE 3a


NHSLA Liability Decision 2
Liability admitted
Report to client, advise on next steps, seek instructions
Is the client self-employed?
YES
Obtain client's accounts, tax returns etc
NO
Prepare quantum witness statement and schedule loss
Calculate offer to settle
Make offer to settle to NHSLA
Negotiations
NHSLA response?
Offer to settle not accepted or no offer made – go to stage 4
Note that 15.6% of claims worth less than £25k will not settle here
Offer to settle accepted
Advise client, claim succeeds
Additional activity - children
1. Prepare application to court for approval settlement;
2. Advise LF (letter) on approval process;
3. Prepare formal solicitor advice/ counsel opinion for court on settlement value.
4. Draft statement for LF confirming advice on costs & funding.
Additional correspondence associated with approval hearing

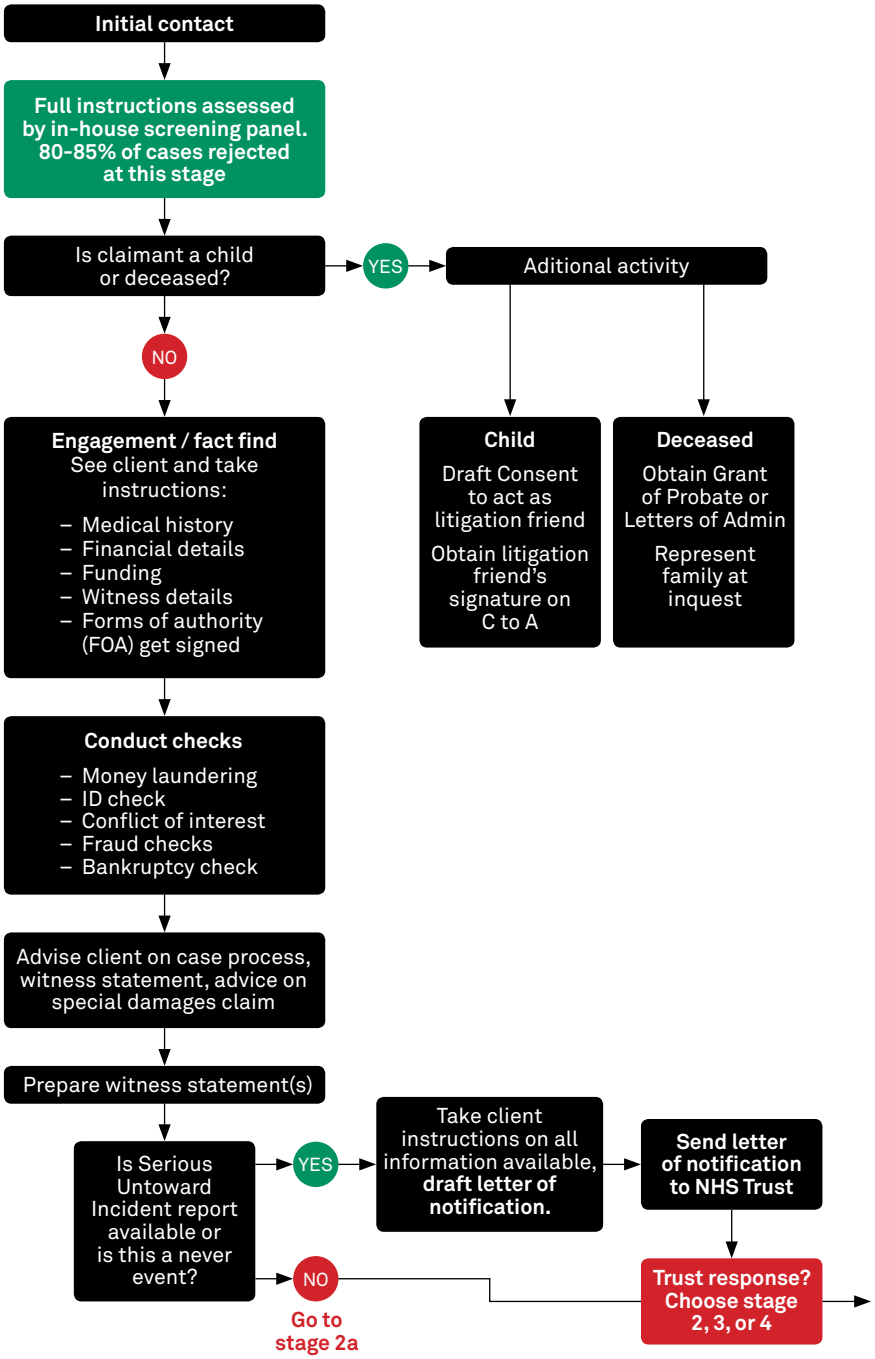
MEDICAL NEGLIGENCE CLAIMS UNDER £25,000

STAGE 4


NHSLA Liability Decision 3
Claim has not settled at stages 2a, or 3a and either liability has been admitted or a % split agreed, or no agreement on liability
Draft claim form, particulars of claim, update witness statement, review medical evidence
Issue proceedings
File at court: Claim form, particulars of claim, medical report
Serve proceedings on NHSLA
15.6% of total claims worth < £25k will now settle or go to trial
15.2% of all claims: offer to settle accepted
Advise client, claim succeeds
Additional activity - children
1. Prepare application to court for approval settlement;
2. Advise LF (letter) on approval process;
3. Prepare formal solicitor advice/ counsel opinion for court on settlement value.
4. Draft statement for LF confirming advice on costs & funding.
Additional correspondence associated with approval hearing
0.4% of all claims do not settle and go to trial instead
Claimant wins at trial 25%
NHSLA wins at trial 75%

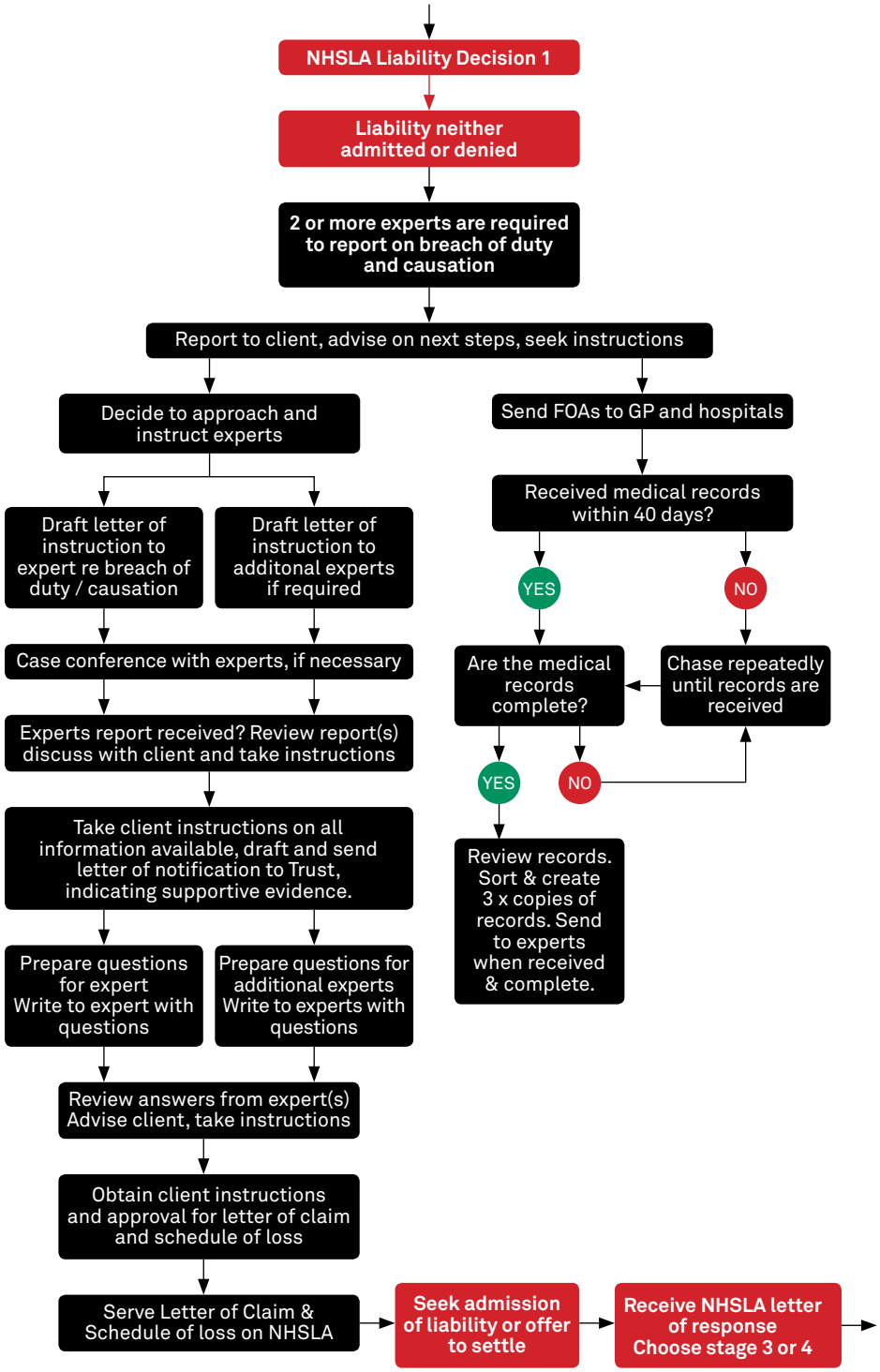
MEDICAL NEGLIGENCE CLAIMS OVER £25,000

STAGE 1


Initial contact
Full instructions assessed by in-house screening panel. 80-85% of cases rejected at this stage
Is claimant a child or deceased?
YES
Aditional activity
NO
Child
Draft Consent to act as litigation friend
Obtain litigation friend's signature on C to A
Deceased
Obtain Grant of Probate or Letters of Admin
Represent family at inquest
Engagement / fact find
See client and take instructions:
– Medical history
– Financial details
– Funding
– Witness details
– Forms of authority (FOA) get signed
Conduct checks
– Money laundering
– ID check
– Conflict of interest
– Fraud checks
– Bankruptcy check
Advise client on case process, witness statement, advice on special damages claim
Prepare witness statement(s)
Is Serious Untoward Incident report available or is this a never event?
YES
Take client instructions on all information available, draft letter of notification.
Send letter of notification to NHS Trust
NO
Go to stage 2a
Trust response? Choose stage 2, 3, or 4

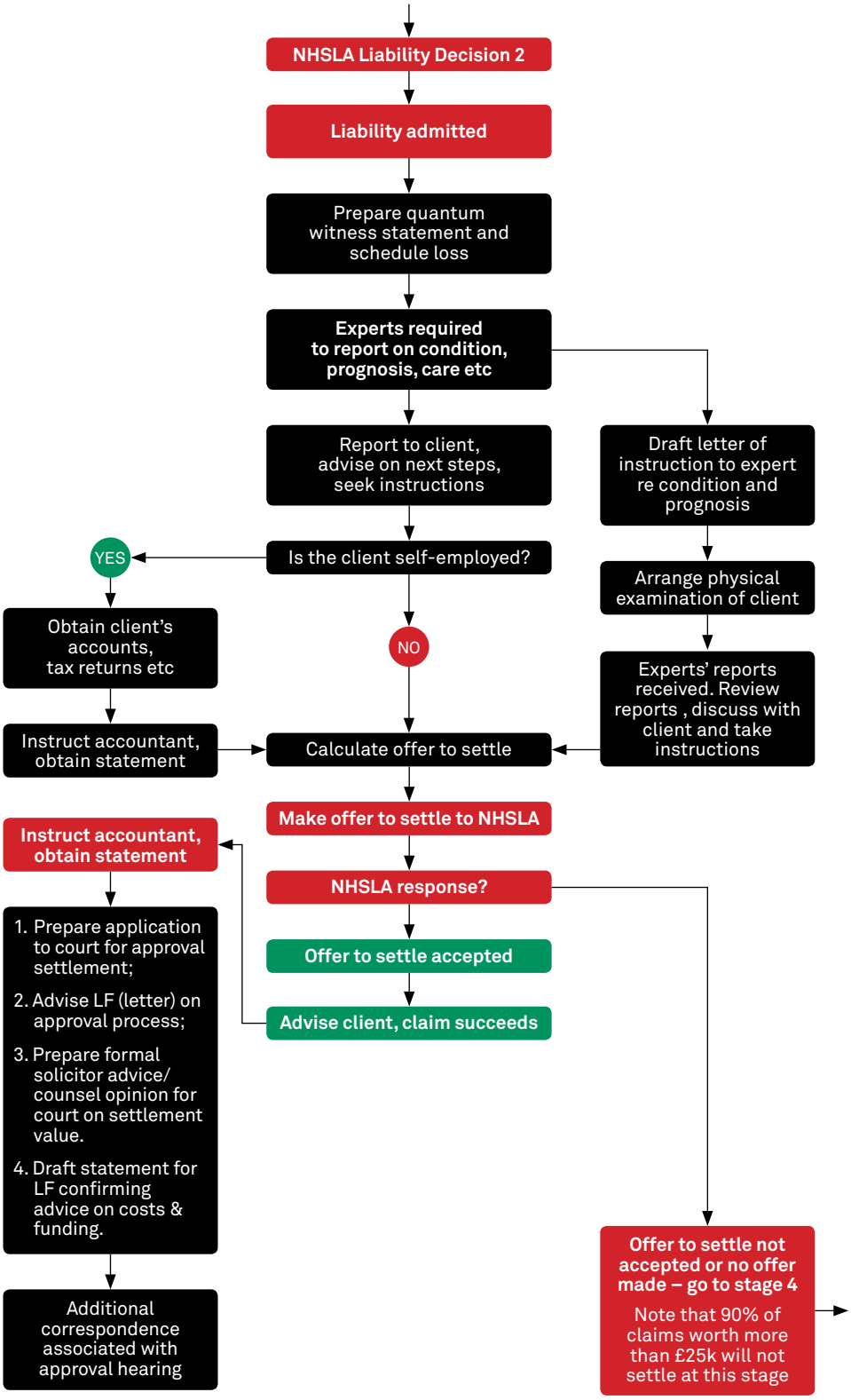
MEDICAL NEGLIGENCE CLAIMS OVER £25,000

STAGE 2


NHSLA Liability Decision 1
Liability neither admitted or denied
2 or more experts are required to report on breach of duty and causation
Report to client, advise on next steps, seek instructions
Decide to approach and instruct experts
Send FOAs to GP and hospitals
Draft letter of instruction to expert re breach of duty / causation
Draft letter of instruction to additonal experts if required
Received medical records within 40 days?
YES
NO
Case conference with experts, if necessary
Are the medical records complete?
Chase repeatedly until records are received
Experts report received? Review report(s) discuss with client and take instructions
YES
NO
Take client instructions on all information available, draft and send letter of notification to Trust, indicating supportive evidence.
Review records. Sort & create 3 x copies of records. Send to experts when received & complete.
Prepare questions for expert Write to expert with questions
Prepare questions for additional experts Write to experts with questions
Review answers from expert(s) Advise client, take instructions
Obtain client instructions and approval for letter of claim and schedule of loss
Serve Letter of Claim & Schedule of loss on NHSLA
Seek admission of liability or offer to settle
Receive NHSLA letter of response Choose stage 3 or 4

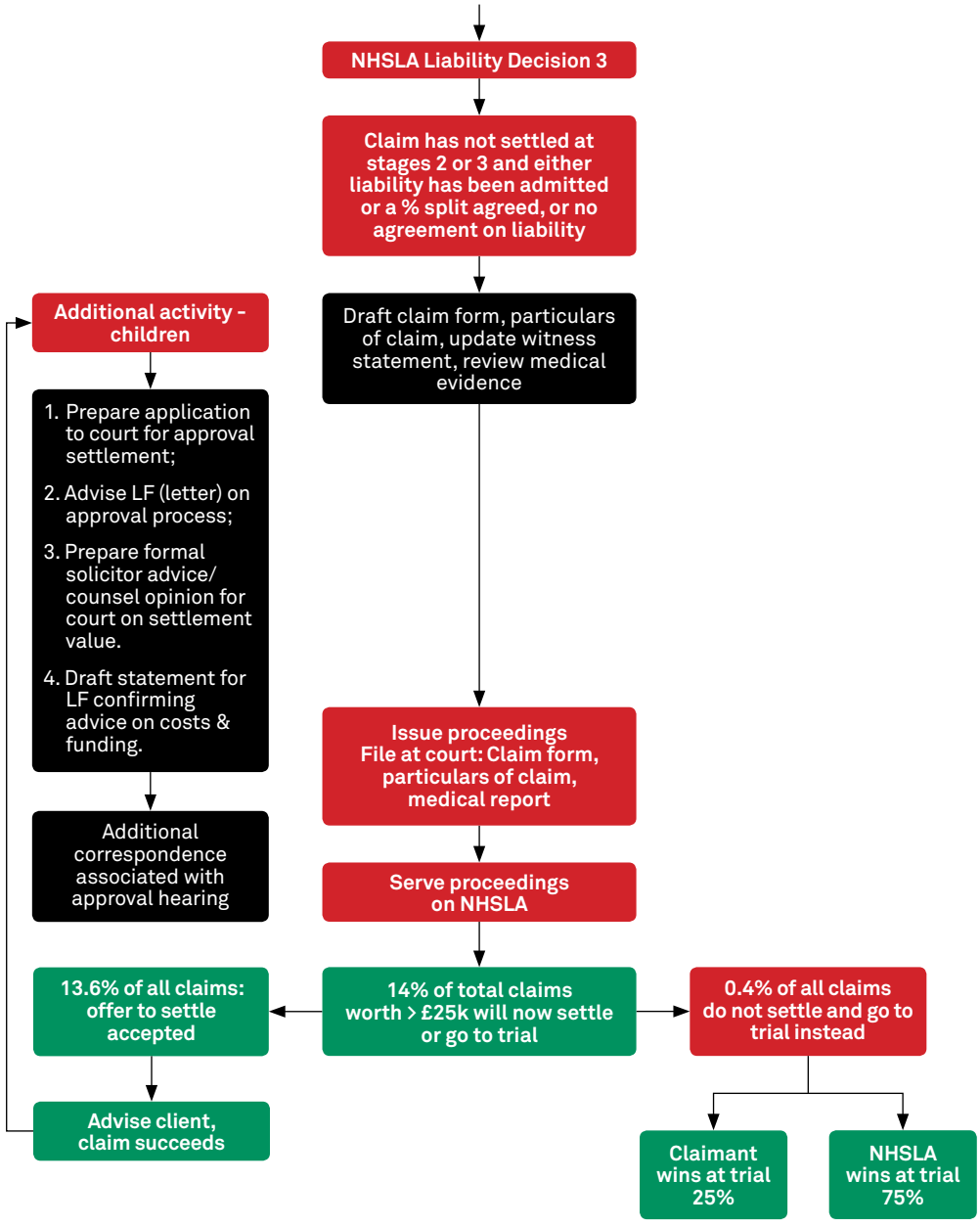
MEDICAL NEGLIGENCE CLAIMS OVER £25,000

STAGE 3


NHSLA Liability Decision 2
Liability admitted
Prepare quantum witness statement and schedule loss
Experts required to report on condition, prognosis, care etc
Report to client, advise on next steps, seek instructions
Draft letter of instruction to expert re condition and prognosis
Is the client self-employed?
YES
NO
Arrange physical examination of client
Obtain client's accounts, tax returns etc
Experts' reports received. Review reports , discuss with client and take instructions
Instruct accountant, obtain statement
Calculate offer to settle
Make offer to settle to NHSLA
Instruct accountant, obtain statement
NHSLA response?
1. Prepare application to court for approval settlement;
2. Advise LF (letter) on approval process;
3. Prepare formal solicitor advice/ counsel opinion for court on settlement value.
4. Draft statement for LF confirming advice on costs & funding.
Offer to settle accepted
Advise client, claim succeeds
Offer to settle not accepted or no offer made – go to stage 4
Note that 90% of claims worth more than £25k will not settle at this stage
Additional correspondence associated with approval hearing

MEDICAL NEGLIGENCE CLAIMS OVER £25,000

STAGE 4


NHSLA Liability Decision 3
Claim has not settled at stages 2 or 3 and either liability has been admitted or a % split agreed, or no agreement on liability
Draft claim form, particulars of claim, update witness statement, review medical evidence
Additional activity - children
1. Prepare application to court for approval settlement;
2. Advise LF (letter) on approval process;
3. Prepare formal solicitor advice/ counsel opinion for court on settlement value.
4. Draft statement for LF confirming advice on costs & funding.
Additional correspondence associated with approval hearing
Issue proceedings File at court: Claim form, particulars of claim, medical report
Serve proceedings on NHSLA
14% of total claims worth > £25k will now settle or go to trial
13.6% of all claims: offer to settle accepted
Advise client, claim succeeds
0.4% of all claims do not settle and go to trial instead
Claimant wins at trial 25%
NHSLA wins at trial 75%

7. Avoiding trials – cutting the cost of expert evidence

The Government is concerned by the cost of medical expert reports and proposes to place limits on these fees.

It is clear from the claimant and defendant budgets we have collected that expert fees can be assumed to increase by 60 to 70 percent if the claim goes to trial. Avoiding trial by making early admissions automatically eliminates this additional expenditure on expert fees.

Our research shows that defendants usually spend as much and sometimes more than claimants. Any cost-cutting restrictions must be even-handed. It cannot be right to allow the defendant to outspend the claimant on more experienced experts to 'trump' the claimant's report. We cannot see how a case in which the court would currently allow the parties five or six experts each for the case to be determined justly could be properly and justly decided in the future if either party is denied the ability to instruct such experts.

If a cap is to be imposed, then only if

- the cap applies to both claimant and defendant, and
- the cap is set at a sensible level,

might it be a fair policy, but only in those circumstances. The proper resolution of medical negligence claims depends upon the evidence of experienced and impartial experts.

8. Improving access to medical records

Digitalisation of medical records should be a NHS priority. Not only will this have obvious benefits to the claims process, but more importantly, it will enable clinicians to provide better care for their patients.

Medical records are obtained by the claimant's solicitor from the claimant's GP and treating hospital. The records will vary depending on the individual. Legal practitioners say that most GP records are relatively manageable in size, although in medical negligence cases, GPs and hospitals are known to supply printouts of a patient's records running to several lever arch files.

Claims would cost less if imperfect processes could be speeded up. Despite living in a digital age medical records are rarely produced within a 40 day period, are often still provided as paper records and are frequently incomplete when received by the claimant's lawyer.

This cannot be right in the 21st century. Not only would digitalised records ensure that the medical records have been supplied in a faster more efficient way, but no longer would both hospitals and claimant lawyers need to spend time and money photocopying paper records.

9. Accreditation

The Legal Aid system had an in-built quality control hurdle which had to be passed in medical negligence cases: lawyers were required to be accredited. Accreditation is a safeguard: to join a specialist panel (such as those run by AvMA, APIL, or Law Society) the lawyer must be experienced in dealing with particular cases and be good at their job.

By way of another example, accreditation is a model adopted by MedCo to improve the quality of medical reporting in low value whiplash cases.

Accreditation is not anti-competitive: it is a standard to which all can aspire. We recommend that accreditation becomes mandatory for medical negligence lawyers undertaking these cases.

Insisting on accreditation, or employing strategies to nudge practitioners towards accreditation will deter the inexperienced solicitor and encourage the specialist. This will save money for the NHS and NHSLA in the long run. Lack of specialisation combined with a sharp downward pressure on legal fees will inevitably lead to additional costs being incurred by the NHSLA as a result of having to deal with incompetent or inexperienced claimant legal representatives.

10. Learning from the Welsh NHS Redress Scheme

We need to learn from past experience with legal reform as to what does and does not work, to avoid repeating past mistakes.

We know from our Welsh practitioner members that the Welsh NHS Redress scheme operating in Wales since 2011 has not evolved as anticipated by the Welsh Assembly. That appears to be because the 'concerns teams' within individual Health Boards have received insufficient training and/or are under resourced. Welsh claimant practitioners report that many cases have to leave the scheme, usually due to severe delays in the NHS response and its gross undervaluation of claims.

We surveyed our Welsh members. Of those who responded, 40 per cent felt that the current Welsh Redress £25,000 scheme threshold was 'about right', although a similar number felt that even £25,000 was too high for a low value scheme. As for the time-scales and procedures in the scheme, 80% felt that they failed to control litigation behaviour, leading to many cases leaving the scheme. No money seems to have been saved.

11. Reducing medical negligence

For every claim made, there is a person whose life has been affected to their detriment. Investing in prevention strategies is money spent on future savings. Sometimes it requires short term spending for long term gain, which can be hard to balance in a budget. But is it right that the NHS is causing brain damage to the same number of babies as it damaged in 2006? How many babies could be saved from this fate if the NHS properly invested in prevention strategies? Reading the case reports of these claims makes depressing reading: the same mistakes are made repeatedly.

The NHSLA has information from thousands of cases every year which can be used to make our hospitals safer, but it is not collecting the data in such a way as to learn from mistakes as quickly as possible. It is no good apologising six years after the event: we must close the loop and help clinicians learn.

Catherine Dixon, CEO of the Law Society and ex-CEO of the NHSLA said "the focus should be on reducing the amount of negligent care which is harming patients in the NHS". She added, "Given this reality [that 41% - almost half a billion pounds of the compensation paid out by the NHSLA- was for obstetric claims, mainly paid to brain-damaged children], plus the fact that almost half of these [legal] costs are arising from brain-damaged baby claims, you would think that every action would be taken to stop damaging babies' brains. If the cost runs into billions and the result is untold misery to babies and their families, isn't it worth investing more to stop this from happening?"[v]

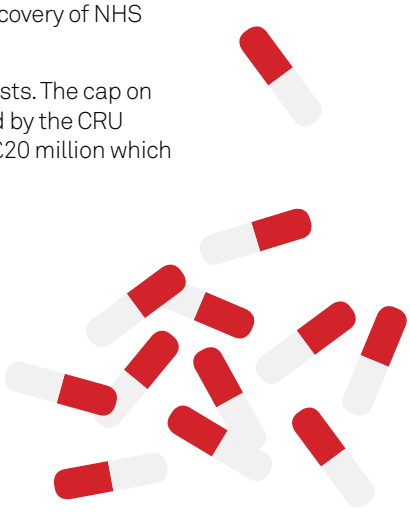
Healthcare providers must collect data in an automatic, objective and systematic way, with the clear aim of improving their patient safety outcome measurements and reducing the numbers of negligence claims made, saving costs in the long term.Management information can be collected and analysed: mistakes can be identified more quickly, compared with similar incidents, trends can be recognised before they become problematic. Medical negligence incidents can be reduced.

12. NHS Recoupment

In our view, the NHS is failing to take advantage of potential revenue streams via the recoupment process.

Following the completion of a successful personal injury claim, some of the ambulance and hospital treatment costs are recoverable from those responsible for causing the injury via the recovery of NHS charges, but the sum which can be recovered is capped.

The NHS has an income stream here that it could exploit further to defray its running costs. The cap on the sums which can be recouped should be lifted or removed. Based on figures provided by the CRU about nine per cent more of the NHS charges which could be recouped – that is nearly £20 million which is not being collected due to the current cap.



13. Reforms commencement date

Any reforms must find a workable date on which to come into force which not only ensures cost savings but also avoids a retrospective effect upon existing claims. Retrospective application inevitably leads to satellite litigation which in turn, increases delays and costs.

Traditionally, reforms in this area of practice have used the date of incident as the date on which reforms will apply so that existing claims remain unaffected. The downside of this is that reforms take longer to deliver cost savings.

When LASPO was introduced, it used the date of funding agreement as the application date.

The Department of Health has proposed in its pre-consultation that the letter of claim should be the commencement date for its reforms. While accelerating cost savings, this would have a retrospective effect on existing claims. The funding advice given to clients by their solicitor at the start of their case and the contractual insurance arrangements already set up would be rendered void. The fundamental basis on which the case was being run would change half way through the process to the detriment of the client.

Strategically, the commencement date which delivers the quickest cost savings, while not having a detrimental retrospective effect is either the date of the funding agreement or the letter of notification, which was introduced in the latest clinical negligence pre-action protocol. This letter is designed to give the NHS / NHSLA early warning of a pending claim and is lodged before the letter of claim and before a lot of the preliminary work (and costs) have been incurred.

In summary

It is important that we maintain a just system to protect those who have been injured through medical negligence whilst lowering the cost of running these claims. In order to achieve the best outcome for the injured person whilst maximising the cost saving objective, we recommend the following:

1. Recognise the savings that will flow from the 'LASPO Act reforms;
2. Fix legal costs and expenses in genuinely low value claims where liability is admitted and at proper levels;
3. Require accreditation of practitioners to ensure quality and competence;
4. Speed up admissions of liability in justified claims –29% of claims are settled after proceedings were issued, the substantial costs of which (including the new, much higher court fees) could be saved;[vi]
5. Avoid trials, cutting the cost of expert evidence;
6. Speed up access to medical records – get digital;
7. Expand NHS Recoupment, generate another £20million (the cost of 850 nurses per year);
8. Apply the best reform commencement date;
9. Learn from the Welsh NHS Redress Scheme;
10. Reduce medical negligence – stop brain damaging babies – save £239,748,852 each year if the numbers of babies being injured is halved;
11. Get smart at the NHSLA – improve consistency of decision-making;
12. Fixing the cost? Fix the process first.

These changes could deliver savings to the NHSLA budget while putting adequate safeguards in place to ensure that we care for those who have been injured through no fault of their own.

i The NHSLA publishes annual data, but it is not possible to ascertain from the data as currently compiled to accurately differentiate between legal costs incurred and the court fees, expert report fees, after-the-event (ATE) insurance premiums (for pre April 2013 claims) and VAT which have also been paid to the injured person's legal representatives, the court service and experts.
ii Latest monthly figures for RTA claims 30 April 2010 - 30 September 2015 - Cumulative Total www.claimsportal.org.uk/en/about/executive-dashboard/
iii Freedom of Information Request F/2501 dated 30 October 2015 – NHSLA to Andrew Ritchie QC
iv Department of Health NHS Litigation Authority Industry Report, April 2011, page 36: Report by Marsh: www.nhsla.com/OtherServices/Documents/Marsh%20report.pdf
v www.lawgazette.co.uk/analysis/comment-and-opinion/costs-and-clinical-negligence/5050646.fullarticle
vi NHSLA response to Freedom of Information Request - F/2525

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